Request for Proposals

2004 – 2005
Ryan White Title II CARE Program
State of Kansas

Funded by the U.S. Health and Rehabilitative Services Administration
of the Federal Government under the Ryan White Emergency CARE Act of 1990

Kansas Department of Health & Environment
Bureau of Epidemiology & Disease Prevention
HIV/STD Section

Sharon Patnode, Bureau Director
Karl Milhon, HIV/STD Section Director

Ryan White Title II CARE Program Directors
David Tritle, Title II/ADAP Director
Angela Toney, Title II/CQI Director

Issued October 24, 2003

Due Date for Proposals:
December 15, 2003
5:00PM

Kansas Department of Health & Environment
BEDP, HIV/STD Section
Ryan White Title II CARE Program
Central Office
1000 SW Jackson, Suite 210
Topeka, KS 66612-1274
785-296-8701

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APPENDICES

October 24, 2003

Since 1991, the Kansas Department of Health and Environment (KDHE) HIV/STD Section has been providing Case Management services to those infected and affected by HIV/AIDS in Kansas through funds provided by the United States Health and Rehabilitative Services Administration (HRSA) of the Federal Government. These funds are available under the Ryan White Emergency CARE Act of 1990. The current and historical funding streams for HIV case management are state general funds (10.3%), CDC Prevention funds (10.7%), and HRSA Title II base award funding, which is approximately 79%. CDC funds are used to support the prevention component of case management.

Attached is a Request For Proposals (RFP) for HIV Case Management and Prevention Case Management (PCM) services for 2004-2005. Funds are available to local governmental agencies (i.e. local health departments) and/or community based organizations for the purpose of providing biopsychosocial, clinical case management, and prevention case management services to HIV/AIDS infected and affected individuals. Eligible agencies must develop and maintain a case management delivery system capable of meeting the requirements of the Kansas Ryan White Title II Standards of Care for Case Management as well as the Kansas Ryan White Title II Manual for Prevention Services for Positives: Prevention Case Management Standards of Practice. Copies of the Kansas Ryan White Title II Standards of Care for Case Management (October 2002 edition) are available upon request. The Kansas Ryan White Title II Manual for Prevention Services for Positives: Prevention Case Management Standards of Practice will be available to all case management contractors during the statewide case management training on November 4-6, 2003 sponsored by KDHE. Requests for copies of this manual by parties responding to this RFP will be honored after November 7, 2003.

Organizations that wish to provide HIV case management services must submit a RFP in the competitive bidding process. Considerations in awarding contracts to providers include the number of clients that have been served in the past, skill and mix of staff, and ability to work with specific target populations. Administrative costs must be less than ten percent of each provider's total budget. Prevention services provided to positive clients are a specific requirement in the contracts. Contracts last for a three-year duration. There is not a separate billing code for prevention case management. Providers report activities performed as part of HIV case management and are linked to the HIV Prevention evaluation program via the web based evaluation system.

Disbursement of funds occurs to agencies through the competitive RFP process for the upcoming fiscal year (July 2004 – June 2005). The awards will be granted in care regions 3 through 9 in varying amounts based upon the level of need of a given region. Regions 1 and 2 fall under Kansas City Missouri Ryan White Title I purview and no funding is provided for those areas. Grants will be awarded for a three-year cycle awarded yearly, with funds dependent upon availability of funding and grantee compliance with continuous quality improvement policies and procedures.

Funding is offered on a competitive basis. Your agency must:

- **Submit a Letter of Intent.** Organizations intending to respond to this RFP are required to notify KDHE, postmarked no later than October 30, 2003.

It is strongly suggested and your agency should:

- **Attend a technical assistance meeting** for all prospective applicants November 4th, 2003 in Wichita at the Kansas University Medical Center Robert's Amphitheater, 1010 N. Kansas from 10:00 am to 3:00 pm or in Topeka, November 12th, 2003 at the public library, 1515 SW 10th Avenue from 1:00 pm to 5:00 pm.

For more information regarding the Ryan White Title II CARE Program Case Management RFP, please contact David Tritle, Title II/ADAP Director, 785-296-8701 or Angela Toney, Title II/CQI Director, 316-337-6136. If you are a new provider and require additional technical assistance during the application process, submit your request with your letter of intent.

Sincerely,

Karl Milhon

Director
HIV/STD Section

Quick Information Page

No applications will be accepted for any reason after the due date of:
5:00pm on December 15, 2003

Letter of Intent:	**Organizations intending to respond to this RFP are required to send a letter of intent postmarked no later than October 30, 2003.**
Technical Assistance Meeting:	November 4, 2003 Wichita, Kansas November 12, 2003 Topeka, Kansas
Proposal Deadline:	December 15, 2003 5:00 PM Kansas Department of Health & Environment BEDP, HIV/STD Section 1000 SW Jackson, Suite 210 Topeka, KS 66612-1274
Anticipated Award Notification:	On or before January 30, 2004
Project Start Date:	July 1, 2004
Proposal Project Period:	July 1, 2004 – June 30, 2005 (12 months)
Copies Needed:	One (1) original and 9 copies of all required items. All original proposals and all copies should be unbound. Use rubber bands.
Not Accepted:	Late proposals will not be reviewed. Faxed proposals will not be reviewed. Incomplete proposals will not be reviewed. Proposals that fail to follow the required format will not be reviewed.
Page Limits:	Narrative must not exceed 20 typed pages; entire proposal limit 40 pages
Eligible Target Populations:	Individuals Infected and Affected with HIV/AIDS
Eligible Applicants:	Local Governmental Agencies (i.e. Local Health Departments), Non-Profit Agencies/Community-Based Organizations in the State of Kansas
For Questions Contact:	Case Management Services: Angela Toney, Title II/CQI Director, phone: 316-337-6136, email: atoney@kdhe.state.ks.us ADAP: David Tritle, Title II/ADAP Director, phone: 785-296-8701, email: dtritle@kdhe.state.ks.us HIV/STD Section Director: Karl Milhon, phone: 785-296-6036, email: kmilhon@kdhe.state.ks.us
Remember:	Use the checklist provided to be sure your proposal is complete.

NOTE: If you hand deliver your proposal, please allow additional time for security procedures in the building lobby.

SECTION A

FUNDED PROGRAMS

I. HIV Case Management

A. Background

The HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) administers all programs funded under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act legislation's major focus is on providing ambulatory health care and support services for individuals living with HIV disease who lack health insurance and financial resources for their care. CARE Act programs reach more than 533,000 individuals each year. The CARE Act was passed in 1990, reauthorized in 1996 and again in 2000 for a five-year period. In 1991, The Ryan White CARE Act supported HIV/AIDS Case Management as a core component in the proper delivery of HIV/AIDS services. The act also mandated case management in rural communities under Title II. Case management services developed into a link between medical and social support services. This resulted in large amounts of available funding for AIDS Service Organizations (ASO), Community-Based Organizations (CBO), and Local Health Departments (LHD) to provide case management services as well as other needed wrap around services.

In 1991, the Kansas Department of Health and Environment, Bureau of Epidemiology and Disease Prevention, HIV/STD Section, began providing HIV Case Management services to those infected and affected by HIV/AIDS in Kansas through funds provided by HRSA under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. To date, there are currently 1,272 HIV infected and affected individuals that receive case management services provided by the Kansas Ryan White Title II CARE Program.

Ryan White Title II Case Management is a comprehensive service delivery system designed to link individuals with needed care components. Enhancing client self-care, independence and self-determination are the primary goals of this program. Clients are expected to be involved in all aspects of their care, including problem-solving functions to the maximum extent possible. Proactive, coordinated efforts by case managers in community-based organizations will assist clients in obtaining optimum wellness, as well as making the best possible use of available resources. Attention to continuity of care will decrease service inaccessibility and fragmentation.

HIV Case management is an approach to non-emergent HIV-related service delivery that is client-centered and community-minded. Case management is comprehensive in scope and provides a means to enhance the quality of life for people affected by HIV. Case management is a system of need and utilization assessment that helps local communities plan and allocate resources while functioning under a specific professional scope of service, ethics, and standards. HIV Case management assesses the needs of the client, their family and social support system. Based upon the assessment, case managers arrange, coordinate, monitor, evaluate, and advocate for a variety of services centered to meet the clients needs.

The role of the Ryan White Case Manager is multi-faceted. Due to the evolving design of the service delivery system, Ryan White Case Managers often manage support services they traditionally refer client to. The traditional scope of services the Ryan White Case Manager provides often becomes

secondary to managing wrap around services. In addition to outreach and intake, the Ryan White Case Manager is responsible for:

- Assessing the individual's need for services;
- Determining availability and feasibility of services;
- Developing a plan of care that includes home and community-based services appropriate to the individual's medical, social, and financial condition;
- Arranging for service delivery;
- Monitoring service delivery;
- Maintaining confidentiality of client records within the service delivery system; and
- Conducting ongoing evaluation of the effectiveness of the plan of care.

B. Statement of Funding

The State of Kansas, the Kansas Ryan White Title II CARE Program and the Kansas Title II Advisory Consortia, as defined that the purpose of funding be to provide care for persons living with HIV infection who are not covered by public or private sources. They also assure that all Kansans living with HIV infection throughout the state have access to the resources to monitor, adhere, and treat infection, in order to achieve the highest quality of life possible.

The services described are supported by a federal grant available through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act from the Human Resources Services Administration (HRSA) and a prevention grant through the Centers for Disease Control (CDC). The Kansas Department of Health and Environment HIV/STD Section Ryan White Title II CARE Program is responsible for administration of Title II programs. Title II funds are to be accessed only when no other support is available, serving as payor of last resort. It should also be noted that services might not be available for the entire year if funds become limited.

The Title II CARE Program in the State of Kansas has been assisting Kansans living with HIV before the enactment of the CARE Act in 1990. These resources included private donations, community-based organizations throughout the state and federal funding for a statewide ADAP (1987). Since this time, the Title II CARE Program has received federal and state funding for assistance with:

- Medications, through the statewide AIDS Drug Assistance Program (ADAP);
- Case Management, which include transportation;
- Primary Care services;
- Dental Care services;
- Mental Health and Substance Abuse (MH/SA) services; and
- Home Healthcare services.

C. Overview of A Urban/Rural Case Management System

There are 7 CARE Regions (See Regions Map in Appendix C) where case management contractors provide Title II services under Ryan White Title II. Case management in rural service areas tend to be limited to psychosocial support due to a noted lack of adequately specialized medical resources, social support networks, inadequate transportation, greater distance to travel for services, and/or the overall lack or presence of specialty services or expertise in the immediate service area. Case management services in rural areas of Kansas have; however, made successful strides in overcoming these barriers by establishing linkages between specialty medical providers for outreach clinics, other community-based organizations, health clinics, and local health departments.

The rural case management system provides a designated case manager who is responsible for all HIV services. The case manager performs an intake and standard eligibility that will include triage to determine urgent needs of the client. The full assessment is usually scheduled at a later date. Clients are self-referred, or have been referred for services by disease intervention specialists (DIS), medical provider, family member, or other agency. Due to large distances and geographic locale of case management office, visits may be conducted at home or at safe neutral sites designated by the client.

In maintaining a continuum of care for clients, health education and risk reduction activities are provided in addition to the medical, nursing, psychosocial, and social work aspects of the HIV Case Management services in Kansas. The focus has gone from providing short-term immediate services to long-term chronic disease management.

D. Certification of HIV Case Management Services

As the front line in providing vital service linkages for people living with HIV/AIDS, case managers must be adequately and appropriately experienced and trained. While imposing a statewide standard for the type of experience required of a case manager is not feasible, training and certification of skills and knowledge by which case managers must possess are both possible and desirable. To achieve this end, the following will guide the training and certification process:

- Minimum education and /or experience requirements of a case manager shall be:
  - An RN with BSN or Social Worker with BSW or other related health or human services degree from an accredited college or university, or
  - Related experience in full time service equivalent to two years regardless of education
- Completion the current KDHE HIV/AIDS testing and counseling certification program, educators certification program and update trainings; and
- All case managers must attend all statewide mandatory case managers meeting/education updates provided by KDHE semi-annually, including statewide Advisory Consortia Meetings.

E. HIV Case Management Reporting Requirements

Agencies awarded the Case Management Contract through this competitive RFP process must develop continuous quality improvement (CQI) activities, which evaluate HIV case management services, including Prevention Case Management (PCM) and Prevention Counseling Services (PCS) based on established CQI standards. Additional resources will be made available at technical assistance trainings. CQI activities may include objective review, independent chart audits, and/or other measures of program performance. These activities will assess the quality, quantity, and outcome effectiveness of case management and prevention services. Self-reporting of agency CQI activities are encouraged and will appear on Case Management Site Visit Reports. Site visits will be conducted by the KDHE CARE Program Title II/CQI Director and/or KDHE CARE Program Title II/ ADAP Director before the annual objective review audit.

All agencies are required to complete the following reports:

Prevention Activities:

Prevention activities must be reported into the web-based evaluation system and must have the computer/technology capacity to perform these reporting requirements by the effective date of the contract.

A PCM Workplan with a Logic Model and Performance Outcomes must be completed by all Awarded Contractors through the 2004 Competitive Request For Proposal for the Kansas Ryan White Title II CARE Program for Prevention Services for Positives. Through the Title II CQI process, a Contractor Technical Assistance Manual and Training for completion of the PCM Workplan, Logic Model, and Performance Outcomes will available to awarded contractors. Additional information regarding these program requirements will reviewed at the technical assistance trainings.

Contractors will have joint site visits and audits with the Title II CQI Director and KDHE HIV Prevention Grants Managers for prevention activities performed under the Kansas Ryan White Title II Prevention Services for Positives Program. The HIV/STD Section under the guidance of CDC and HRSA has successfully implemented an internal CARE/Prevention Collaboration between the Kansas Ryan White Title II CARE Program and KDHE HIV Prevention. The CARE/Prevention Collaboration within KDHE was implemented in May 2002. Additional information regarding the CARE/Prevention Collaboration within KDHE will be released at the technical assistance trainings as well as HIV CPG Meetings and Kansas Ryan White Title II Consortia.

Contractor Quarterly Reporting Form:

The Contractor Reporting Form includes information on clients served by your agency during a given quarter. Required information to report includes: total number of **unduplicated clients** served in your service area and/or by your agency, demographics including race, ethnicity, gender, age, and services provided (advocacy, direct service, or referral).

Affidavits of Expenditures:

The Affidavits of Expenditure are submitted quarterly with the Contracting Reporting Form. This information includes, but is not limited to, a budgetary breakdown of funds to be received for continuation of grant funding. These line items include salaries, materials, transportation and indirect costs.

Annual Universal Client Satisfaction Survey Tool:

All agencies must ensure the performance of an annual universal client satisfaction survey tool provided by KDHE. Agencies may also introduce additional evaluation criteria exceeding the recommendations provided by the KDHE. KDHE Title II/CQI Director will monitor whether a client satisfaction survey has been completed.

Workplans:

All agencies must submit completed workplans for Prevention Case Management noting performance outcomes measurement and monitoring. Workplans are descriptions of the overall activities to be performed by the agency. This includes the format, setting, and delivery mechanism of the intervention; a realistic plan for reaching the client(s); quality assurance and accountability mechanisms; collaboration efforts; and evaluation to ensure constancy of the intervention or the direct service provided. The workplan may be described in a narrative format and/or graphically via a logic model. Additional information regarding the CARE/Prevention Collaboration within KDHE will be released at the technical assistance training for awarded contractors.

Requests for technical assistance on reporting requirements may be addressed by the Title II/CQI Director or the Title II/ADAP Director by email or phone. On-site technical assistance in available for all contractors by appointment.

For more information about the Kansas Ryan White Title II CARE Program and/or to download a copy of the Standards of Care go to:
http://www.kdhe.state.ks.us/hiv-std/ryan_white_care.html

II. Prevention Case Management

A. Background

Prevention Case Management (PCM) has been adopted in Kansas to promote and maintain risk-reduction behaviors and to bring partners of HIV-infected individuals into the health care system. Prevention case management is a service that is integrated into the regular Ryan White Case Management System for individuals infected with HIV. PCM is an enhancement of the mission of the existing case management system. Begun in 1999, PCM is a case management service under the Kansas Ryan White Title II CARE Program. Historical funding for PCM has been provided with approved CDC funds in the amount of $50,000 per grant year. The HIV/STD division of the Kansas Department of Health and Environment administers PCM under the Ryan White Title II CARE Program.

PCM is available to any client enrolled in the Ryan White Title II case management system. Eligibility for prevention case management is based on one's PCM Acuity Scale and Risk Assessment. All case managers are certified in HIV/AIDS case management, counseling, and testing. Services include risk assessment and the development of client-specific case plans, based on standardized tools that are assessed annually. Specific prevention activities include safer sex education, social skills training, self-esteem counseling, and substance abuse treatment. PCM relies on case managers as sources of referral for prevention services. PCM also serves as a potential access point for eligible partners and family members who are related to or affected by HIV-infected individuals already enrolled in the case management system. In 1999, nine HIV-positive partners of enrolled clients were identified through PCM and were subsequently brought into the care system.

A total of 540 PCM sessions were provided to HIV positive and high risk HIV-seronegative clients in the year 2000. In 2001, a total of 598 PCM interventions were provided to specified target populations. During 2002, a total of 776 PCM sessions were provided to HIV infected and affected clients. In 2002, the types of clients receiving PCM include HIV-infected clients, High-risk HIV-negative clients, and clients with Unknown Serostatus. Of the 776 PCM sessions provided, 523 PCM sessions were provided to HIV-infected clients; 224 PCM sessions were provided to High-risk HIV-negative clients; and 29 PCM sessions were provided to clients of Unknown Serostatus. The average number of PCM sessions per client is 2.

B. Statement of Funding

This category of funding links traditional Ryan White Title II Case Management to PCM to assure ongoing prevention services to persons at highest risk for HIV acquisition, transmission, or re-infection. **PCM must not duplicate Ryan White CARE Act case managemen**t for persons living with HIV, but may be integrated into these services.

NOTE: Organizations may not apply only to provide Ryan White Title II Case Management or PCM. Applications for funding INCLUDE Prevention Case Management.

To fulfill program obligations, applicants will need to demonstrate the willingness to enhance their current capacity to provide case management services with the additional funds for PCM. Applicants may consider utilizing PCM funds to hire additional professional and/or paraprofessional staff that meet the minimum requirements of Ryan White Case Managers for PCM services. Additional paraprofessional staff would be used to enhance the linkage between prevention and care services.

PCM funds must be used as intended. Expenditures for PCM will be monitored and if not used to the extent intended, will be re-allocated. These expenditures will be monitored through the Quarterly Contractor Reporting Form, data reported on Evaluation Web system, Contractor Site Visits and/or Annual Audits, and agency budget and Affidavits of Expenditure as information available to KDHE HIV/STD Section.

C. Staff qualifications for PCM

All case managers delivering this intervention to eligible clients must be certified in the following: HIV/STD Basic Training, Basic HIV Program: Fundamentals and Prevention Skills, Orasure Testing, and Behavior Change Counseling Strategies. These courses are offered by KDHE and are minimum requirements for case manager certification in the Kansas Ryan White Title II Case Management Standards of Care. Additional information about certification courses offered by KDHE can be found on our website.

At a minimum, case managers must successfully complete the KDHE PCM training and must be trained in the basic philosophy and techniques of Prevention Case Management in addition to Prevention for Positives. PCM staff must be provided written job descriptions and opportunities for regular, constructive feedback. All staff must be knowledgeable of Kansas Statutes and Regulations related to HIV/AIDS, as well as internal agency confidentiality policies and procedures.

In considering staff qualifications agency administrators may choose to have professionally trained staff serve as prevention case managers and carry out all PCM activities. PCM activities include those related to assessment, prevention planning, and risk-reduction counseling. Other agency administrators may apply a team approach to PCM, using both professionals and paraprofessionals (Case Manager Assistant).

Paraprofessionals (Case Manager Assistant), under the supervision of a case manager, may be effective in assisting with functions such as intake, screening, data entry into Evaluation Web, and follow-up assistance to ensure coordination of care.

Professionals may be more appropriate for performing the functions of PCM requiring more sophisticated skills such as assessment, prevention planning, and HIV risk-reduction counseling. If a team approach is used, an explicit and structured means for professionals (prevention case manager) and paraprofessionals (case manager assistant) to communicate must exist. Staff qualifications, then should be based on the skills required to complete the various PCM functions or activities as required in the Prevention Case Management Standards of Practice. All staff must be knowledgeable of confidentiality policies and procedures.

The essential components of a PCM program along with suggested minimum staff qualifications are grouped into two main categories:

Category 1. **Essential Components:**

Client engagement, screening, and coordination of services.

Suggested Minimum Staff Qualifications:

(Paraprofessional would meet the minimum requirements for Category 1.)

Knowledge of the target population; cultural and linguistic competence; knowledge of HIV/AIDS and other STDs; knowledge of available community services, and effective communication skills.

Category 2. **Essential Components:**

Assessment; development of a prevention plan; HIV risk reduction counseling, monitoring and reassessment; on-going support and relapse prevention, and discharge planning.

Suggested Minimum Staff Qualifications:

(Professionals would meet the minimum requirements for Category 2.)

A bachelor's degree or extensive experience in a human-services-related field, such as social work, psychology, nursing, counseling, or health education; skilled in case management and assessment techniques; skill in counseling; ability to develop and maintain written documentation (progress notes); skill in crisis intervention; knowledgeable of HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change principles and strategies; and cultural and linguistic competence.

Note: Professionals would meet the minimum requirements for both Category 1 and 2.

III. Prevention Services for Positives

Prevention services for HIV positive individuals will be delivered through the Kansas Ryan White Title II Case Management Program. Kansas Ryan White Title II Case Managers will provide HIV+ Clients and Identified Partners with Prevention Case Management and Prevention Counseling Services. Due to the increased need of prevention services provided to Ryan White clients, PCM has been developed into a formalized component of the Ryan White Title II Case Management System. PCM is a distinct activity from HIV Case Management, however, PCM has been successfully integrated as a direct service in Ryan White to Kansans living with HIV and AIDS since 1999. The primary goal is to provide quality and efficient PCM services to HIV infected and affected individuals about safer sex behaviors to reduce HIV transmission.

A. HIV Prevention Case Management

Prevention Case Management (PCM) is a hybrid intervention for providing both time-limited case management and HIV prevention. The premise of PCM is that by helping high-risk persons address their most pressing medical and psychosocial needs in a supportive, case management relationship, (1) they will be able to prioritize and understand HIV prevention, and (2) they may be better able to remove themselves from high-risk situations or environments.

Source: Definition of PCM. Summary Section 4.0. CDC Literature Review and Current Practice, September 1997

PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is the most intensive individual level intervention and is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV

acquisition, transmission, or reinfection. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance use/abuse, STD treatment, mental health, and social and cultural factors. A strong relationship with STD clinics, TB testing sites, substance abuse treatment programs, and other health service agencies is essential to successfully recruiting or referring persons at high risk who are appropriate for this type of intervention. PCM should be offered to both HIV-infected and seronegative persons who continue to practice risky behaviors.

PCM consists of seven essential components. Each component is listed below with the minimum set of standard for each component. Additional PCM guidance is located in the document entitled HIV Prevention Case Management Guidance, September 1997. The document is available on the web at www.cdc.gov/hiv/PUBS/pcmg/pcmg-doc#mark1.0 or may be obtained from the CDC National AIDS Clearinghouse at 1 (800) 458-5231.

1. Client Engagement

Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period. The frequency of contact will be determined by the prevention case managers assessment and completion of the PCM Acuity Scale.

2. Screening and Assessment

All persons screened for PCM, including those who are considered not to be appropriate for PCM, must be offered counseling by the prevention case manager and referrals relevant to their needs. Thorough and comprehensive assessment instruments must be obtained or developed to assess HIV, STD, and substance abuse risks and their medical and psychosocial needs. All PCM clients must participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks, as well as their medical and psychosocial needs. Prevention case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

3. Development of a Client-Centered Prevention Plan

For each PCM client, a written prevention plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change. For persons living with HIV and receiving antiretroviral or other drug therapies, the prevention plan must address issues of adherence. The prevention plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptoms status. For clients with substance abuse problems, the prevention plan must address referral to appropriate drug and/or alcohol treatment. Clients must sign off on the mutually negotiated prevention plan to ensure participation and commitment. Client files that include individual prevention plans must be maintained in a locked file cabinet to ensure confidentiality.

4. HIV Risk-Reduction Counseling

PCM promotes multiple-session HIV risk-reduction counseling aimed at meeting identified behavioral objectives. Training and quality assurance for prevention case managers must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies. Clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs.

Prevention case managers must develop a protocol for assisting HIV seropositive clients in confidentially notifying partners themselves or eliciting names and locating information for local health department notification and referring them to PCM and/or prevention counseling and testing services. For partners of HIV seropositive clients who are not aware of their HIV antibody status, prevention case managers must ensure that partners receive information regarding the potential benefits of knowing their HIV status. For HIV seropositive persons receiving treatment for opportunistic infections and/or antiretroviral therapy, counseling to support adherence to treatments/therapies must be provided.

5. Coordination of Services with Active Follow-Up

Formal and informal agreements, such as memoranda of understanding, must be established with relevant service providers to ensure availability and access to key service referrals. A standardized written referral process for the PCM program must be established. Explicit protocols for structuring relationships and communication between case managers or counselors in different organizations is required to avoid duplication of services, for example, how to transfer or co-manage PCM clients with substance abuse or mental health case management. Communication about an individual client with other providers is dependent upon the obtainment of written, informed consent from the client. A referral tracking system must be maintained. Annual assessment of relevant community providers with current referral and access information must be maintained. A mechanism to provide clients with emergency psychological or medical services must be established. *Applicants are responsible for submission of a written crisis intervention plan with their proposal.*

Important Note:
PCM involves referral to the following services: substance abuse treatment, mental health counseling, STD diagnosis and treatment, women's health services, TB diagnosis and treatment, and other primary health care services. PCM services are not intended to be a substitute for extended social services, medical case management, or psychosocial care. Specific PCM services may include skills building, individual counseling, couples counseling, crisis management, resource procurement, and preparation for referral of partners.

6. Monitoring and Reassessment of Clients' Needs and Progress

Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes. A protocol must be established for defining minimum, active efforts to retain clients. That protocol should specify when clients are ready to be made "inactive." The frequency of client and prevention case manager contact will be determined by the client's level of acuity. However, the frequency of contact may increase or decrease based upon a significant change in any of the life areas assessed by the prevention case manager on the PCM Acuity Scale.

7. Discharge from PCM Upon Attainment and Maintenance of Risk-Reduction Goals

The client will be discharged from PCM services when the client's level of acuity is a Basic, Stage 1 and the client has maintained risk reduction goals for a period of six months. The prevention case manager will have a final counseling session with the client at the end of the six-month period before the client is discharged. The client will have the option to voluntarily remain active in PCM

and/or re-enter the PCM process.

Resources for Prevention Case Management:

1. CDC HIV Prevention Case Management Guidance, September 1997. To view this document go to http://www.cdc.gov/hiv/pubs/hivpcmg.htm
2. CDC Literature Review and Current Practice, September 1997. To view this document go to http://www.cdc.gov/hiv/pubs/pcml/pcml-doc.htm
3. Guidelines for Health Education and Risk Reduction Activities. CDC Division of HIV/AIDS Prevention, 1995. To view this document go to http://www.cdc.gov/hiv/HERRG/HIV_HERRG.htm

B. HIV Prevention Counseling and Testing

HIV prevention counseling is individual counseling provided by certified case managers to assist clients in assessing their personal risk for HIV, reinforcing previous attempts to change behavior, creating an appropriate, time-phased plan to reduce their risk, and enhancing the risk reduction skills the clients need to put the plan into action.

The following elements should be part of all **HIV prevention counseling and testing** sessions:

1) **Keep the session focused on HIV risk reduction**.
Each counseling session should be tailored to address the personal HIV risk of the client rather than providing a predetermined set of information. Although case managers must be willing to address problems that pose barriers to HIV risk reduction (e.g., alcohol use in certain situations), case managers should not allow the session to be distracted by the client's additional problems not related to HIV. Certain counseling and testing techniques (e.g., open-ended questions, role-play scenarios, attentive listening, and a non-judgmental and supportive approach) can encourage the client to remain focused on personal HIV risk reduction.

2) **Counseling sessions should include an in-depth, personalized risk assessment.**
Sometimes called "enhancing self-perception of risk," risk assessment allows the case manager and client to identify, acknowledge, and understand the details and context of the client's HIV risk. Keeping the assessment personal, instead of global, will help the client identify concrete, acceptable protective measures to reduce personal HIV risk. The risk assessment should explore previous risk-reduction efforts and identify successes and challenges in those efforts. Factors associated with continued risk behavior that might be important to explore include using drugs or alcohol before sexual activity, underestimating personal risk, peer influences, self-efficacy, factors that encourage unsafe practices, and perceived vulnerability.

3) **Acknowledgement and support of positive steps already made.**
Exploring previous risk-reduction efforts is essential for understanding the strengths and challenges faced by the client in reducing risk. Support for positive steps already taken increases the clients' beliefs that they can successfully take further HIV risk-reduction steps. For some clients, simply agreeing to an HIV test (Orasure) is an important step in reducing risk.

4) **Clarify critical rather than general misconceptions.**
In most instances, case managers should focus on reducing the client's current risk and avoid discussions regarding HIV transmission modes and the meaning of HIV test (Orasure) results. However, when clients believe they have minimal HIV risk but describe more substantial risk, the case manager should discuss the HIV transmission risk associated with specific behaviors

or activities the clients describe and then lower-risk alternatives.

5) **Negotiate a concrete, achievable behavior-change step that will reduce HIV risk.**
Although the optimal goal might be to eliminate HIV risk behaviors, small behavior changes can reduce the probability of acquiring or transmitting HIV. Behavioral risk-reduction steps should be acceptable to the client and appropriate to the client's situation. For clients with several high-risk behaviors, the case manager should help clients focus on reducing the most critical risk they are willing to commit to changing. The step does not need to be a personal behavior change. For many clients, knowledge of a partner's recent HIV status might be more critical than personal behavior changes. The step should be relevant to reducing the client's own HIV risk and should be a small, explicit, and achievable goal, not a global goal. Identifying the barriers and supports to achieving a step, through interactive discussion, role-play modeling, recognizing positive social supports, or other methods will enhance the likelihood of success. Writing down the goal might be useful. Clients with ongoing risk behaviors must be referred to additional prevention and support services.

6) **Seek flexibility in the prevention approach and counseling process.**
Case managers should avoid a one-size-fits-all prevention message. Behaviors that are safe for one person might be risky for another. The length of counseling sessions will vary depending on client risk and comfort.

7) **Provide skills-building opportunities. Depending on client needs, the case manager can demonstrate or ask the client to demonstrate problem-solving strategies including**:
1) communicating safer sex commitments to new or continuing sex partners; 2) using male latex condoms properly; 3) trying alternative preventive methods (e.g., female condoms); 4)cleaning drug-injection equipment if clean syringes are unavailable; or 5) communicating safer drug-injection commitments to persons with whom the client shares drug paraphernalia

8) **Use explicit language when providing HIV test results.**
Test results should be provided at the beginning of the follow-up session. Case managers should never ask the client to guess the test results. Technical information regarding the test can be provided through a brochure or other means so the session can focus on personal HIV risk reduction for clients with negative tests and other considerations for clients with positive or indeterminate test results. In-depth technical discussions of the "window period" should be avoided because they could confuse the client and diffuse the importance of the HIV prevention message. Case managers should clarify that negative test results do not mean the client has no HIV risk and work with the client to reconsider ongoing HIV risk behaviors and the benefits of taking steps to reduce those risks. A client with ongoing risk behaviors should not be given a false sense of safety of those behaviors.

The following counseling elements are considered necessary for high-quality **HIV prevention counseling**.

1) **Ensure that the client returns to the same case manager.**
Consistency of the client and case manager relationship helps the client feel secure, reduces misunderstanding, and promotes the likelihood of effective risk reduction. Effective counseling models tended to use the same counselor for all sessions. When follow-up prevention counseling sessions must be provided by a different counselor, careful record keeping is necessary to ensure high-quality counseling.

2) **Use a written protocol to help case managers conduct effective sessions.**
A structured protocol outlining session goals can help keep the case manager focused on risk reduction. The protocol can include examples of open-ended questions (To help a new case manager avoid closed-ended questions) and a list of explicit risk-reduction steps (to help a new case manager avoid accepting a client's suggestion of global risk reduction steps).

3) **Ensure ongoing support by supervisors and administrators.**
Supervisory support is essential for effective counseling. Training in HIV counseling approaches that focus on personal risk reduction is recommended for persons supervising case managers. Staff appraisals should acknowledge that completion of critical counseling elements has higher priority than completion of paperwork.

4) **Avoid using counseling sessions for data collection.**
Paperwork should be completed at the end of the counseling session or by staff members who are not counseling. Checklist risk assessments driven by data collection forms are detrimental to effective counseling because they can encourage case managers to use closed-ended questions, limit eye contact, and miss critical verbal and nonverbal cues. The relevance of any routinely collected data should be periodically assessed.

5) **Avoid providing unnecessary information.**
An emphasis on providing information might prompt case managers to miss critical HIV prevention opportunities and cause clients to lose interest. Discussion of theoretical HIV risks tends to shift the focus away from the client's actual HIV risk situations to topics that are more "comfortable" or easy to discuss but irrelevant to the client's risk

Resources for HIV Counseling and Testing:

1. "The New Yellow Book" Revised Guidelines for HIV Counseling, Testing, and Referral. November 9, 2001. Issued by KDHE. January 7, 2002. Effective July 1, 2002. Copies available upon request. Email **aturner@kdhe.state.ks.us**
2. Revised Guidelines for HIV Counseling, Testing, and Referral: Technical Expert Panel Review of CDC Guidelines for HIV Counseling, Testing, and Referral. MMWR November 9, 2001/50(RR19);1-58. To view this article go to **http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm**

SECTION B

APPLICATION REQUIREMENTS

Cultural Competency

Agencies responding to this RFP need to recognize and factor into program design the target population's cultural, racial/ethnic, linguistic, geographic, economic and demographic diversity. **All agencies responding to this RFP must submit a current copy of their internal sexual harassment policy and procedure as well as internal policy and procedure for responding to client grievances.**

1. Agencies must collaborate with other service systems that target the population such as physical health, human services, mental health, substance abuse, criminal justice, and others. HE/RR interventions must link clients who test positive with early intervention health services in addition to PCM services if deemed appropriate.

2. Service providers must demonstrate their capacity for effective service delivery in order to provide culturally appropriate and relevant care to Kansans living with HIV/AIDS.

3. Applicants must demonstrate their ability to provide culturally competent services to a diverse population. Cultural competence involves understanding the social, linguistic, ethnic, and behavioral characteristics of a community and applying that understanding in the delivery of HIV case management services. Two resources are suggested to assist organizations in assuring the delivery of culturally competent and linguistically appropriate services.

    - The Office of Minority Health of the U.S. Public Health Services has published standards for assuring cultural competence, *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* A summary of the 14 recommended standards appears in Appendix A. A complete discussion of the standards is available at http://www.omhrc.gov/CLAS/finalcultural1a.htm.

    - The Gay, Lesbian, Bisexual and Transgender Health Access Project of the Massachusetts Department of Public Health has published *Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual, and Transgendered Clients*. Appendix B is checklist for agencies to use to evaluate the extent to which the standards are being met. The complete listing of the standards is available at http://www.glbthealth.org/index7.html.

Special Conditions

The Federal Government (CDC and HRSA) and the State of Kansas provide funding for this RFP. All funded contractors and subcontractors must be in compliance with all administrative requirements and programmatic policies of the funding agencies.

The following requirements and restrictions apply to all agencies and proposals:

1. No funds may be used to purchase or improve land, or to purchase, construct, or make permanent improvement to any building.
2. Funds may not be used to make payments to recipients of services.
3. All providers must participate in the region's HIV-related community based continuum of prevention and care.

4. Services must be provided by the project sponsor in facilities that are accessible to people with physical disabilities in accordance with the Americans with Disabilities Act.
5. No funds may be used to support services that are reimbursable under any other program.
6. HIV/AIDS services shall be provided free of charge.
7. HIV health and support services provided must be made without regard to the individual's ability to pay, the individual's past or present health condition, and in a setting accessible to low-income individuals.
8. Special efforts must be undertaken by all recipients of grant funds to reach out to low-income individuals to make them aware of the availability of services.

Goals

The primary goal of this RFP is to insure equitable and quality access to all Kansans living with HIV/AIDS to the Ryan White Title II CARE Program, specifically linkage to case management services. The agencies selected must demonstrate an ability to communicate with and have access to the community to be served for the entire CARE Region of the contract. Agencies must demonstrate an ability to successfully work with this population in the services provided through case management and have access to a network of community resources to meet the needs of the clients. Collaboration with local health departments and other agencies is vital to the successful performance of this contract. The agency must demonstrate an ability to secure other funding sources to meet the needs of case management that are not provided for within the constraints of this funding source.

If multiple contracts are awarded within one region, agencies will be required to closely coordinate client and clinical care with other awarded contractors. Applicants are urged to coordinate with other agencies in the region prior to submission of applications to reduce potential conflicts.

The Proposal

Proposals submitted to KDHE-HIV/STD Section, Ryan White Title II CARE Program must follow the basic outline described below. The entire proposal should not exceed 40 typed pages, excluding the budget. The budget justification and supporting documentation must be submitted as attachments to your application. Quantity is not important, but quality is important.

Narrative

Applicants should prepare a narrative section justifying why they should be funded. Applicants may seek information from KDHE-HIV/STD Section, Ryan White Title II CARE Program on specific expectations, which will be found in the Standards of Care. Other data such as epidemiological demographic information may be gathered from the local health department or the KDHE web site. The narrative should include, but is not limited to the applicants experience and information in the following areas:

1. A brief history and understanding of the agency and the structure of the agency.
2. Description of the agencies past history with HIV/AIDS care.
3. Description of the agencies experience in working with a diverse and changing infected and/or affected population.
4. Description of the agencies practices in making its services available to all segments of the designated care region.
5. Describe current and proposed mechanisms for ensuring services are made available to all who may seek them.
6. Describe the confidentiality policies of the agency, and the security systems of the agency and provide assurances of maintaining client records within these very closely monitored policies. Copies of the written

agency policies regarding confidentiality and security should be attached to this application as supporting documentation.

7. Describe specific objectives and mechanisms for meeting these objectives to be achieved in meeting the Standards of Care.
8. Describe the qualifications of the current and/or proposed staff to meet the objectives of this project. Job descriptions and resumes should be attached to this application as supporting documentation.
9. Describe and include supporting documentation of other funding sources used or proposed for use in meeting the needs of clients that are not covered within the constraints of this grant.

Budget (complete attached forms)

Applicants should prepare a detailed annual budget using the following format as appropriate.

1. Personnel: list position, annual salary, and amount of time dedicated to this program.
2. Travel: estimate amount of expense to be used in travel for client related activities.
3. Other Direct Cost: detail each estimated cost and the percentage of that cost expected from this grant. (examples of acceptable expenses are pagers, internet access, postage, copies, telephone etc.)
4. Administrative Cost: detail administrative cost limited to 15% of the grant amount. This cost will include supervision, overhead and general administration.

Using separate columns, indicate the expected total expenses, the amounts requested from the grant and the amount expected from other funding sources.

Supporting Documentation

Please attach the following documentation:

1. Recent letters of support for your case management services as well as letters of support and commitment from other agencies you are likely to cooperate with in delivery of case management services.
2. Letters of support and/or other documentation demonstrating your agencies ability to perform equitable and quality case management throughout the care region for which you are requesting funding.
3. Copies of confidentiality and security policies for your agency.
4. Job descriptions and resumes of your current and/or proposed case managers.
5. Documentation of other funding sources available to your agency to meet the cost of case management services. (**submit copy of recent audit if your agency is non-profit with 501-(c)3 status**)

Monitoring, Evaluation, and Reporting

One of the keys to delivery of Ryan White Title II HIV services in Kansas is collaboration within KDHE, its administrative agencies, and contractors in program and fiscal performance monitoring. The collaboration begins with the development of formal work statements describing the service and reporting commitments of contracted providers, and extends through the delivery of services to qualified recipients. Your proposal will form the basis for these work statements and serve as a standard for measuring implementation progress throughout the year. This is part of the continuous quality improvement process.

KDHE is responsible for program monitoring, evaluation, and reporting on contractors. This process is ongoing through regular interactions between the Program Directors and Contractors working together on behalf of the persons targeted to receive these services. The goal of these activities is to assure the efficient, timely, and appropriate delivery of high quality HIV services.

Contractors awarded funds through this RFP will be required to submit both an Affidavit of Expenditure and a Contractor Quarterly Reporting Form on **a quarterly basis** in order to obtain reimbursement.

Proposal Review and Notification Process

All proposals will be objectively reviewed by an established Peer Review process. The Peer Review Team will rank the proposals and recommend allocations to KDHE for final approval. Recommendations are based on the quality and responsiveness of the proposal and other factors such as past performance of the applicant. The final award decisions are based on the Peer Review Team's recommendations.

KDHE reserves the right to conduct site visits and perform record reviews of applicant organizations during the proposal review process. Applicant organizations are required to submit a statement giving KDHE the right to conduct such site visits (a sample is included with the required forms).

Final notification of the outcome of the review process will occur on or about January 30, 2004. A letter is sent to each applicant organization indicating the funding decision related to their proposal. No other information about the decision process will be released, although applicants may request **in writing** to be provided with a summary of the reviewers' comments.

The weighting scheme used by the Peer Review Team appears below.

Element	Weight
Ability and capacity to meet standards	50 points
Applicant's accessibility to the care region	25 points
Case Management Objectives	15 points
Budget	10 points
Total	100 points

Responsibilities of KDHE

The Secretary of the Kansas Department of Health and Environment will award one or more contracts to each CARE Region for HIV Care/Prevention Case Management up to the amounts outlined in Appendix C of this document. The funded applicants will receive payments according to the schedule prescribed within the contracts after review of quarterly reports from the contractors.

If you have any questions about these requirements or how to meet them, please call Angela Toney, Title II/CQI Director at (316) 337-6136, David Tritle, Title II/ADAP Director at (785) 296-8701 or Karl Milhon, HIV/STD Section Director, at (785) 296-6036.

SECTION C

APPLICATION INSTRUCTIONS

General Instructions

Section	Recommended Pages	Possible Points
Proposal cover sheet	Use attached form (Attachment #7)	Not scored
Summary	1 page	Not scored
Case Management Narrative (HIV Case Management & Prevention Case Management)		
Narrative	2 pages min. (8 pages. Max)	30 points
Supporting Documentation	Only attach specified documents as outlined in RFP	15 points
Agency Organization		
Structure and staffing	3 pages and Appendix B	15 points
Data and evaluation capacity	3 pages	15 points
Financial		
Budget	Use attached form (Attachment #)	25 points
TOTAL POSSIBLE		100 points

All items outlined are **required** of all applicants with the addition of the following:

1. Section D: Required Forms;
2. Detailed program budget and justification; and
3. Board of Directors List

Document Requirements

- Use 8½" by 11" paper.
- Use 1" margins on all sides of each page.
- Use 12-point type
- Text must be either 1½ or double-spaced. Do not single space the narrative.
- Place all components of the proposal in the order indicated above.
- Number each application page consecutively, beginning with the title page numbered "1" through the last page of the entire application including attachments.
- Use the section headings (number and title) used in the RFP. For example, the section describing, "Section __: Structure and Staffing," and each part within Section __ should be headed "A ..., B ..." etc.

Tables and forms must be submitted in print form. Electronic submissions will not be accepted.

SECTION D

REQUIRED FORMS

Tables and forms must be submitted in print form. Electronic submissions will not be accepted. Not all sections described will have an electronic form. Some of the information below may require additional paperwork that you will have to submit as supporting documentation or as an attachment to your proposal.

Organizational Chart

The applicant agency will furnish an organizational chart of their agency structure and staff along with their proposal. There is no standard form provided in the RFP for the organizational chart. This must include a Board of Directors List.

Client, Staff and Board of Directors Demographic Information

The applicant agency will furnish this information in addition to the organizational chart. For existing contractor agencies, client demographic information can be compiled from agency Contractor Quarterly Reports.

Organizational Budget

The applicant agency must complete attached budget forms and submit these forms along with their proposal along with the DETAILED program budget and justification.

Proof of non-profit status, such as a copy of your IRS 501(c)3 letter

The applicant agency must submit a copy of this document, if applicable, with their proposal.

Authorization from Board of Directors (See KDHE Attachment # 4)

Applicant agencies that are governed by a Board of Directors must submit a notarized authorization letter with their proposal.

Copy of most recent Audit

Applicants with 501(c)3 status must submit a copy of their most recent audit (for 2002). Only one copy of the audit needs to be submitted with the original copy of the proposal. Do not make 10 copies of the audit – it is not required for the RFP Peer Review Process.

Checklist For a Complete Submission

The enclosed form is not required for submission with your proposal. The checklist is for your convenience to ensure your proposal is complete.

Proposal Checklist

Applicants are required to submit the proposal checklist (See KDHE Attachment #6) as the cover page of their proposal.

ATTACHMENT 1

SAMPLE AUTHORIZATION FROM BOARD OF DIRECTORS

The following statement must be submitted on the proposing organization's letterhead and notarized. The Chair or President of the Board of Directors or other designated Board member must sign the letter. If the authorization is signed by anyone other than the Chair or President, a separate letter signed by the Board Chair or President must be attached designating that individual to do so.

YOUR AGENCY LETTERHEAD

Karl Milhon
Director
HIV/STD Section
Bureau of Epidemiology and Disease Prevention
Kansas Department of Health and Environment
1000 SW Jackson, Suite 210
Topeka, KS 66612-1274

Dear Mr. Milhon:

I, **[insert name of Chair or President of your agency's Board of Directors]***, for and on behalf of the governing body of* **[insert name of agency]** *certify that the Board of Directors reviewed and approved the attached proposal for competitive funding of Ryan White Title II Case Management Services in Kansas for 2004. I understand the term of funding, if awarded, is for a period of three years.*

I certify that **[insert name of organization]** *agrees to allow the Kansas Department of Health and Environment to conduct a site visit during the review of this proposal.*

I further certify that the information included in this proposal is true and accurate to the best of my knowledge and that the organization named above agrees to abide by the terms of this RFP and currently has and will maintain the capacity to implement the proposed program.

Signature: _____

Title: _____

Date: _____

ATTACHMENT 2

CATAGORICAL BUDGET FOR GRANT SUBMISSION
[AGENCY NAME]

A. PERSONNEL $

[List each position. Give a brief job description of 50 words or less. For each position listed, multiply the monthly salary or wages by the percentage of personnel time by the number of months which the salary is to be paid from this budget.]

EXECUTIVE DIRECTOR: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

ACCOUTANT: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

RYAN WHITE CASE MANAGER: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

[POSITION TITLE]: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

[POSITION TITLE]: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

[POSITION TITLE]: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

B. FRINGE BENEFITS $

[Itemize the cost of fringe benefits paid for employees, including employer contributions for Social Security, retirement, insurance and unemployment compensation. Fringe benefits requested must represent the actual benefits paid for employees.]

FICA	_____ **x $**_____	$
INSURANCE	**COST x (NUMBER) FTEs**	$
WORKER'S COMP	**RATE x SALARIES**	$
UNEMPLOYMENT	**RATE x SALARIES**	$

C. SUPPLIES $

This category is for the costs of materials and supplies necessary to carry out the contract. It includes general office supplies, janitorial supplies, and any equipment with a purchase price, including freight, of less than $1000 or less per item.]

Phone (Land Line/s)	**RATE/mnth X 12 months**	$
Phone (Cell-phone/Pagers)	**RATE/mnth X NUMBER staff x 12 months**	$
Internet/Email	**RATE/mnth X 12 months**	$
Postage	**RATE/mnth X 12 months**	$
Utilities	**RATE/mnth X 12 months**	$
Copies	**RATE/mnth X 12 months**	$
General Office Supplies	**RATE/mnth X 12 months**	$
Printing	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$

D. CAPITAL EQUIPMENT

Capital costs such as the purchase of office equipment, typewriters, copying machines, video equipment, cameras, televisions, VCR's etc. will not be funded. Computer equipment leases and Internet access caosts required for reporting are allowable expenses.

E. TRAVEL $

[Budget the projected costs of transportation, lodging, meals, and related expenses for official staff business travel conducted in carrying out the contract. Costs for travel to the Kansas Title II Advisory Consortia Meetings held three times a year should be included, if Applicable. NOTE: Grantees who do not have written travel reimbursement policies must use KDHE travel reimbursement rates.]

EXECUTIVE DIRECTOR: [NAME] (If Applicable)

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

ACCOUTANT: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

RYAN WHITE CASE MANAGER: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

PREVENTION OUTREACH: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

HIV TESTING PRE- AND POST TEST COUNSELOR: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

SUPPORT STAFF: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

F. OTHER $

[DEFINITION: All other allowable direct costs **NOT LISTED** in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

contracts for administrative services
data processing services
contract clerical or other personnel services
exterminating services
insurance and bonds
books, periodicals, pamphlets, and memberships
registration fees
space and equipment rental
printing and reproduction expenses
janitorial services
security services
equipment repairs or service maintenance agreements
advertising
training costs, speakers fees and stipends

[ITEM]	[PURPOSE]	ANNUAL COST
		$
		$
		$
		$
		$
		$
		$
		$
		$

G. TOTAL DIRECT COSTS $

[Enter totals from SECTIONS A THRU E noted above]

H. TOTAL INDIRECT COSTS $

[A copy of the current negotiated indirect cost rate must be attached, if applicable. If there is no negotiated rate, applicant may recover up to 10% of the direct salary and wage costs of providing the service, excluding overtime and fringe benefits, subject to adequate documentation of salary and wage costs.]

I. TOTAL BUDGET $

ATTACHMENT 3

Proposal Cover Sheet
Ryan White Title II Case Management Services
Kansas Department of Health and Environment
HIV/STD Section

PLEASE PRINT OR TYPE

Organization Name:			
Address:			
City/State and ZIP			
Organization Tax ID Number *			
Contact Person & Title			
Contact Person Email			
Contact Person Phone/Fax			
Principal Site Where Services will be Provided:			
Address:			
City & ZIP			
Anticipated Number of Clients to be Served in Region:			

CHECK (X) TO ENSURE ALL WORKPLANS ARE COMPLETED FOR THIS PROPOSAL

HIV CASE MANAGEMENT	COMPLETED:
PREVENTION CASE MANAGEMENT	COMPLETED:
PREVENTION COUNSELING	COMPLETED:

ATTACHMENT 4

QUICK NOTIFICATION OF INTENT TO RESPOND

Ryan White Title II CARE Program 2004
Competitive RFP Process
Kansas Department of Health & Environment

When mailed, this page must be postmarked on or before October 30, 2003

This attachment NOT necessary if letter of intent has already been submitted

Organizations intending to respond to this RFP **MAY** notify KDHE using this form. **This quick notification form does not replace your formal letter of intent.** Any information relating to this RFP will be sent to the person designated below as the organization contact person. **PLEASE PRINT**

Organization Name _____

Street Address _____

City _____

State/Zip Code _____

Contact Person _____

Title _____

Phone _____

Fax _____

Email _____

1. Have you applied for Ryan White CARE Act funds in the past? ☐ Yes ☐ No
2. Are you a new applicant to the Ryan White CARE Act in the State of Kansas? ☐ Yes ☐ No
3. Do you have Internet access? ☐ Yes ☐ No
4. What location will be convenient for you to attend a technical assistance training regarding this RFP (Please check one)
   ☐ Topeka ☐ Garden City ☐ Wichita

☐ Check if you are new applicant AND requesting one-on-one program development technical assistance during the proposal writing stage.

Thank you for your submission.

ATTACHMENT 5

CARE RFP Checklist for a Complete Submission

Each proposal is considered complete when ALL the following items are provided:

- ❑ Proposal Cover Sheet
- ❑ Proposal Narrative
- ❑ Case Management Sites Information Form
- ❑ Organizational Chart
- ❑ Client, Staff and Board of Directors Demographic Information
- ❑ Proposed Work Plan for HIV Case Management, Prevention Case Management, and Prevention Counseling
- ❑ Budget
- ❑ Prevention Case Management Emergency Crisis Intervention Protocol
- ❑ Proof of non-profit status such as your IRS 501(c)3 letter
- ❑ Board of Directors List
- ❑ Authorization from Board of Directors Letter, Signed and Notarized
- ❑ Detailed program budget and justification
- ❑ Proposal Checklist
- ❑ Letter of Intent Submitted by October 10, 2003 by 5:00pm (Quick Notification by Fax can be used, but does not replace the formal Letter of Intent submitted on your agency letterhead stationary).
- ❑ A copy of your 2002 audit. If a 2002 audit is not available, provide a 2001 audit with an explanation as to why your 2002 audit is not available and timeline for when it will be. Only one copy is required; do not include it in the 10 photocopies you are required to submit of the application.
- ❑ Copies of your agencies internal sexual harassment policy and procedure
- ❑ Copies of your agencies internal client grievance policy
- ❑ Schedule to attend a Technical Assistance Training
- ❑ Request copies of important documents to complete your RFP, including the Kansas Ryan White Title II Standards of Care and the "The New Yellow Book" Revised Guidelines for HIV Counseling, Testing, and Referral. These resources are available at the KDHE website at www.kdhe.state.ks.us
- ❑ Epidemiological data needed for your RFP is also available online at the KDHE website

APPENDIX A

Assuring Cultural Competence in Health Care:

Recommendations for National Standards and an Outcomes-Focused Research Agenda

Recommended Standards for Culturally and Linguistically Appropriate Health Care Services

Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these proposed standards were developed with input from a national advisory committee of policymakers, providers, and researchers. In the [full report], each standard is accompanied by commentary that addresses its relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

Preamble:

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policymaking, operations, evaluation, training and, as appropriate, treatment planning.

4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.

8. Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in service areas.

9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.

11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

13. Develop structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

APPENDIX B

Cultural Competency Agency Checklist for Gay, Lesbian, Bisexual, and Transgendered Clients

The following checklist can help you assess whether your organization's existing policies and procedures meet provisions for quality services to Gay, Lesbian, Bisexual, and Transgendered Clients. This may also assist your agency in developing standards for equitable care GLBT clients. Check all that apply.

Does your organization:

- ❑ Actively recruit gay, lesbian, bisexual, and transgender employees in its hiring practices, including advertising employment opportunities in GLBT publications.
- ❑ Have written policies regarding diversity, non-discrimination, and sexual harassment that explicitly include gay, lesbian, bisexual, and transgender employees.
- ❑ Support and encourage visibility of gay, lesbian, bisexual, and transgender employees.
- ❑ Have formal procedures for addressing employee complaints of discrimination or harassment based on sexual orientation or gender identity.
- ❑ Work to ensure that gay, lesbian, bisexual, and transgender employees of all ages have the same benefits and compensation as all other employees, including family benefits.
- ❑ Train personnel about GLBT-related benefits issues.
- ❑ Have written policies explicitly prohibiting discrimination based on sexual orientation and gender identity in the provision of services.
- ❑ Have written procedures for clients to file and resolve complaints regarding discrimination based on sexual orientation or gender identity.
- ❑ Use inclusive intake and assessment forms and procedures that are culturally appropriate for gay, lesbian, bisexual, and transgender clients.
- ❑ Train intake and assessment staff to assure that they provide medically and culturally appropriate care and referrals within and outside the agency.
- ❑ Provide ongoing diversity, harassment, and anti-discrimination training for staff around GLBT issues as they pertain to the agency's services.
- ❑ Provide comprehensive training so that all direct care staff can identify and address basic GLBT health issues within the scope of their expertise.
- ❑ Identify staff with special expertise in and sensitivity to GLBT issues.
- ❑ Have a comprehensive list of resources and relationships with other agencies to facilitate appropriate referrals for GLBT health and social services within and outside the agency.
- ❑ Include and address sexual orientation and gender identity in all case management and treatment plans when it is necessary and appropriate to client care.

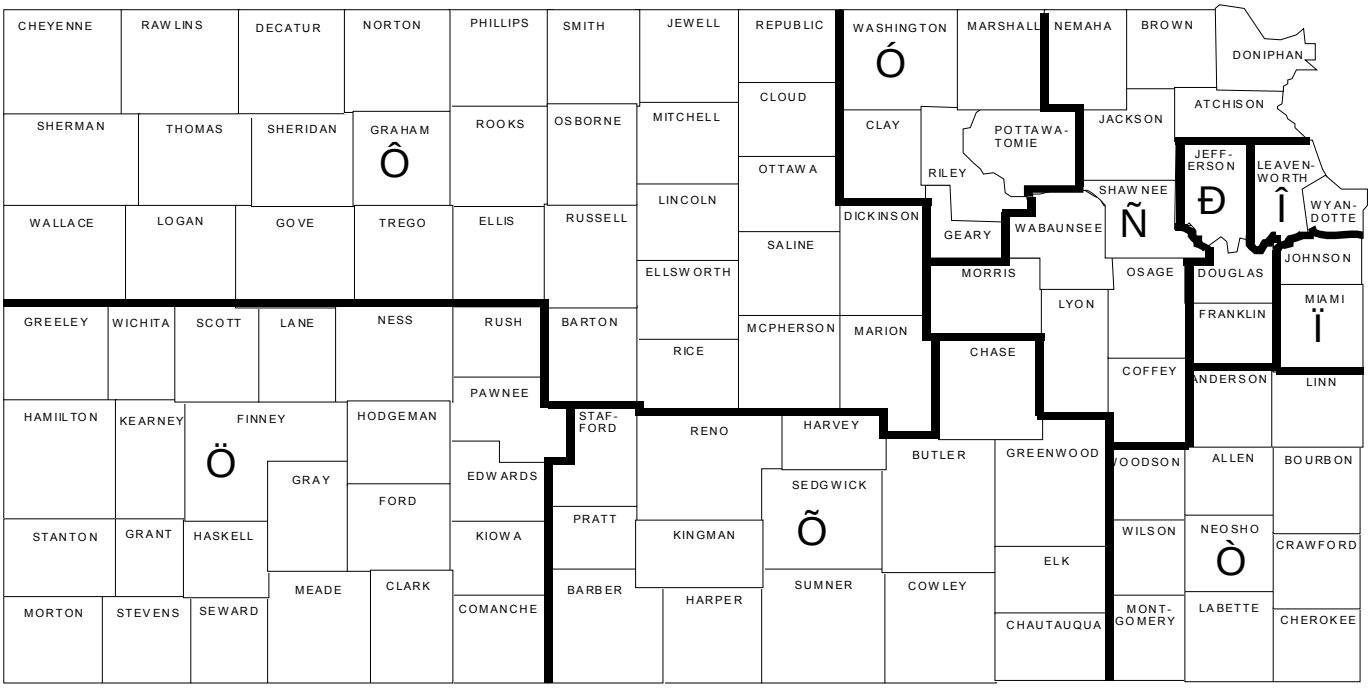
Source: The Gay, Lesbian, Bisexual and Transgender Health Access Project of the Massachusetts Department of Public Health has published *Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual, and Transgendered Clients*.

APPENDIX C

REGIONAL GRANT OFFERINGS AND REGIONAL MAP

Region	Title II Services (#)	Title II Services (%)	Prevalent HIV/AIDS (#)	Prevalent HIV/AIDS (%)	Case Managers Supported FY2004 (1=$30,000)	FY2004 CM Award	Client Services Travel	FY2004 Total Award
3	26	4%	52	6%	1.75	$ 51, 420	$ 1,080	**$ 52,500**
4	82	13%	126	14%	2.5	$ 73,500	$ 1,500	**$ 75,000**
5	28	4%	41	5%	1.75	$ 51, 420	$ 1,080	**$ 52,500**
6	38	6%	47	5%	1.75	$ 51, 420	$ 1,080	**$ 52,500**
7	51	8%	64	7%	2	$ 58,920	$ 1,080	**$ 60,000**
8	369	58%	510	57%	7.5	$ 221,900	$ 3,100	**$ 225,000**
9	39	6%	50	6%	1.75	$ 51, 420	$ 1,080	**$ 52,500**
Total	**633**	**100%**	**890**	**100%**	**19**	**$ 560,000**	**$ 10,000**	**$ 570,000**

Transportation allocations will be provided to each site in the amounts indicated above. This allocation must be used for direct care client related activities **and** must be included in the submitted budget.



APPENDIX D

SUMMARY OF CDC INTERVENTION TYPES

I. Individual-level Interventions (ILI)

ILI provides health education and risk-reduction counseling with a skills component provided to one individual at a time. A risk reduction skills component can be cognitive (you get people to think about their own risks and how they might reduce risks) and/or behavioral (you get people to practice risk reduction skills).

ILIs assist clients in:

- offering on-going assessment of their own behavior;
- planning for individual behavior change;
- facilitating linkages to clinic and community settings that support behaviors and practices that prevent HIV transmission;
- helping clients to make plans for obtaining needed services.

Excludes outreach and prevention case management. While individuals are the focus of the following interventions, they are separate interventions.

II. Group-level Intervention (GLI)

Health education risk reductions counseling with a skills component provided to groups (more than 1 person) of varying sizes. GLIs use peer and non-peer models and include:

- wide range of skills
- information
- education
- support

Excludes "1-shot" educational presentations (general education activities or lectures without a skills component). This type of educational presentation is considered Health Communication/Public Information.

III. Prevention Case Management (PCM)

PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk reduction needs. PCM is a hybrid of HIV risk reduction counseling and traditional case management with multiple sessions.

PCM provides intensive, ongoing and individualized:

- prevention counseling
- support
- service brokerage.

IV. Counseling, Testing and Referral/ Partner Counseling and Referral Services (CTR/PCRS)

CTR component: Voluntary HIV testing in both confidential and anonymous formats that includes:

- obtaining informed consent

- providing client-centered HIV prevention counseling
- whenever possible, HIV testing
- referral to appropriate medical, prevention and psychosocial services.

PCRS component: A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others.

Partner notification can be provided in four ways: 1) by the client, 2) by the provider or disease intervention specialist, 3) jointly by the client and provider, or 4) contract.

PCRS helps partners gain:

- earlier access to individualized counseling
- HIV testing
- medical evaluation and treatment and
- other prevention services.

V. Health Communications/Public Information (HC/PI)

HC/PI is the delivery of planned HIV/ AIDS prevention message through one or more channels to the target audience to:

- provide information that increases awareness or builds general support for safe behavior
- support risk-reduction efforts and
- inform persons at risk for infection how to obtain specific services.

It excludes group interventions with a skills component.
HC/PI channels include the following:

- Electronic media: Means by which information is electronically conveyed to large groups of people (e.g., city, region or statewide) including radio, television, public service announcements, new broadcasts, infomercials.
- Print media: These formats also reach a large-scale or nationwide audience, and include printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.
- Hotline: Telephone services (local or toll-free) offering up-to-date information and referral to local services (e.g., counseling and testing; support groups).
- Clearinghouse: Interactive electronic outreach systems using telephones, mail, the Internet to provide responsive information service to the general public as well as high-risks populations.
- Presentation/Lectures: These are "one-shot" educational interventions that are information-only activities conducted in group settings

VI. Community Level Interventions

CLI seeks to improve risk conditions and behaviors in a community by focusing on the community as a whole, instead of focusing on individuals or small groups.

CLI alters social norms, policies, or characteristics of the environment. This can be done through community mobilizing, social marketing, community-wide events, policy and structural interventions.

Source: Guidelines for Health Education and Risk Reduction Activities. CDC Division of HIV/AIDS Prevention, 1995.

APPENDIX E

NASTAD PREVENTION INTERVENTIONS

1. **Popular Opinion Leader:**

   POL is a community-level intervention that identifies, trains and enlists key opinion leaders to encourage safer sexual norms and behaviors. Targets MSM but can be used with other populations at risk. Agency staff recruit and train opinion leaders to disseminate risk-reduction messages in strategic conversations within their social networks, and recruit and train new waves of opinion leaders. *Agency capacity needed:* contacts with community gatekeepers and ability to work within social networks; health department Trainers/Coaches provide training and technical assistance on identifying social networks, recruitment, role play exercises, evaluation, and intervention maintenance.

2. **Voices/Voices**

   A group-level intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants are grouped by gender and ethnicity in order to view English or Spanish videos in a single-session intervention. Agency staff use videos to trigger discussion, teach condom use and negotiation skills, educate on condom features and distribute condoms. *Agency capacity needed:* bilingual staff (for Spanish version), and the ability to work with clients while the provision of other services continues uninterrupted. Health Department Trainers/Coaches provide training and technical assistance on recruitment and group facilitation skills, balancing fidelity with adaptation.

3. **Community Promise**

   A community-level intervention that targets a range of groups at high risk, such as IDU's, MSM, sex workers or youth. Agency staff conduct community identification, write role model stories based on client interviews that model safer sex or safe injection practices. Community advocates distribute stories and risk reduction supplies. *Agency capacity needed:* street knowledge, community outreach, community assessment skills (interviews, focus groups), familiarity with stages of change theory to interview and stage target population, ability to write role model stories. Most benefit is derived when organizational teams (2-3 staff members) attend a training. Health Department Trainers/Coaches provide training and technical assistance on community assessments, peer volunteers, writing/distributing effective stories and program evaluation.

4. **RAPP**

   A community mobilization program designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. The intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals, and condom distribution; small group safer sex discussions and presentations; peer interaction with community organizations and businesses to participate in media campaign with distribution of role model stories and health information newsletters and brochures. *Agency capacity needed:* community assessments, staff to recruit and train peer outreach volunteers on stage-based encounters, street knowledge, community outreach, ability to write role model stories, gain support of community organizations and businesses, conduct small group activities, including safer sex parties and HIV presentations. Health Department Trainers/Coaches provide training and technical assistance on community networking, role model story development, and small group activities.

5. **Street Smart**

   A multi-session, skills building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address youths' social skills, assertiveness and coping through exercises on problem solving identifying triggers and harm reduction. Agency staff also provide individual counseling and trips to community health providers. *Agency capacity needed:* scheduling eight 2-hour

sessions that include role-playing and videotaping, sensitivity to the lifestyle and knowledge level of youth at risk. Health Department Trainers/Coaches provide training and technical assistance on facilitation, adaptation of core elements, and curriculum management.

6. SISTA

A peer-led group-level training intervention designed for African-American women to reduce HIV risk behavior, recently used by Latina and Caucasian groups. Peer facilitators deliver sessions in a community-based setting. Agency staff teach assertiveness, self-esteem, condom use, gender/ethnic pride, and sexual decision-making. *Agency capacity needed:* ability to identify and recruit exceptional peer facilitators with strong interpersonal skills. Health Department Trainers/Coaches provide training and technical assistance on AIDS education, facilitation and process monitoring.

7. Brother to Brother

A group-level behavioral intervention for African American self-identified gay and bisexual men. The program uses a culturally appropriate curriculum to reduce HIV risk behavior. Agency staff are peers who facilitate groups on skill building and role-playing. Agency staff teach risk reduction, negotiation and assertiveness skills. *Agency capacity needed:* staff who represent the population, are cognizant of their own identities relative to race and sexual orientation and can foster the development of positive self-identity among participants. Health Department Trainers/Coaches provide training and technical assistance on facilitation, group-level intervention skills, recruitment and outreach.

8. Safety Point

A multi-session, group and individual-level intervention to reduce HIV transmission and infection risk between IDU's and crack users, who are not in drug treatment. Counselors use role-model videos and counseling/support sessions to assist clients in selecting appropriate personal HIV risk reduction goals to modify their high-risk drug and sexual behaviors. *Agency capacity needed:* long-term commitment; outreach workers and behavioral counselors with expertise working with active drug users teach risk reduction, facilitate workshops, and provide counseling to individuals and small groups. Participant incentives needed to encourage ongoing participation.

APPENDIX F

Key Behavioral and Social-Level Theories in HIV Prevention Selected Behavioral Theories

Behavioral theories help clarify the reasons people behave as they do and assist in developing or identifying interventions that can influence HIV risk behavior.

Where there is little information on evaluated interventions, behavioral theory can be used to help estimate which approaches are more likely to be effective.

A brief overview appears below of selected behavioral theories and the factors they jointly identify as critical determinants of HIV risk behavior.

Health Belief Model

A health education approach used to explain a wide variety of prevention and screening behaviors, including HIV risk. Postulates four key health beliefs that produce a readiness to act:

- perceived personal susceptibility,
- perceived severity of the condition,
- perceived efficacy of the behavior,
- barriers to the behavior.

Cues to action are often considered necessary to initiate action once readiness is above threshold. Personal and social characteristics can modify the behavior.

Theory of Reasoned Action

A social psychological approach dealing with relations among beliefs, attitudes, intentions, and behavior used to understand health behaviors in a variety of domains, particularly HIV. Based on the assumption that behavior will change if the cognitive structure underlying the behavior changes at one or more of four levels:

- intention to perform the behavior;
- personal attitudes and social factors that affect the intention to perform;
- perceived positive outcome underlying attitude; and
- normative beliefs (about individuals and groups) and motivation to comply with these norms.

Choice of factor(s) to address is based on empirical research with the target population.

Social Cognitive Learning Theory

An approach rooted in learning approaches to psychology and clinical psychology applications based on a relationship among the person, behavior, and environment.

Two sets of cognitions are important in changing behavior: 1) outcome expectations, whether the person thinks the behavior will lead to positive, rather than negative consequences; and 2) self-efficacy, the person's belief in his/her capability and confidence in performing the behavior. The importance of self-efficacy is a particular contribution of Social Cognitive Learning Theory.

Common Theoretical Factors Affecting HIV Risk Behavior

Expected Outcomes (attitudes): Believes that the benefits outweigh the disadvantages.

Intention: Strong positive intention to perform the behavior.

Skills: Possesses the skills to perform the behavior. Self-efficacy: Believes he/she can perform the behavior.

Emotion: Believes the behavior will produce a positive, rather than a negative emotional response.

Self-standards: Believes the behavior is consistent with self-image.

Perceived Social Norms: Perceives greater social pressure to perform the behavior than not to do it.

Barriers: Experiences fewer environmental constraints to perform a behavior than not to do it.

Stages of Change Trans-theoretical Model: How Do People Change Their Behaviors?

Often referred to as "Stages of Change," the Trans-theoretical Model proposes that behavior change occurs in a series of stages. Individuals start with no intention to change, form weak intentions, strengthen these intentions, try the behavior inconsistently at first, then finally adopt the new behavior as a routine part of their lives.

Effective interventions first determine where the individual or population is on the continuum of behavior change and move them to a subsequent, more advanced stage. To be effective, intervention methods and messages must be targeted to the specific needs and stage of an individual or group.

The various factors from the three major theories above can help move persons from stage to stage.

The five stages of change appear below.

Stages of Change

1. *Pre-contemplation:* No intention to change, unaware of risk, deny consequences of risk behavior.
2. *Contemplation:* Aware a problem exists, seriously thinking about overcoming it, have not yet made a commitment to action.
3. *Preparation:* Intend to take action in the near future, may have taken in consistent action in recent past.
4. *Action:* Modifies behavior, experience, or environment to overcome problem; change is relatively recent.
5. *Maintenance:* Works to prevent relapse and maintain behavior change over a long period of time.

Selected Social-Level Theoretical Approaches: How do Social Environments Affect Individual Behavior?

Prevention programs benefit from consideration of a broader range of theoretical approaches and models. The transmission of HIV infection between individuals occurs within the context of social networks: family and friends, the immediate community, the society as a whole.

Community-level theories based on social science concepts help explain the influences on individuals of their personal networks and social environments and contribute to developing effective HIV prevention interventions. Below is a quick reference to several social-level theories and models.

Diffusion Theory

Illustrates the process by which an idea or practice is spread throughout a social system from person to person by way of particular channels. Diffusion theory considers the characteristics of the cultures involved as well as a given innovation to determine whether it is more or less likely that a particular group or culture will adopt the innovation.

Leadership-Focused Models

Combines aspects of diffusion theory and community organizing theory. Naturally emerging leaders within groups are encouraged to exhibit and communicate an innovation to their peers. Because these innovations may be different from the group's established behaviors or social norms, these models are focused on how risk-reduction strategies become the norm within a social structure. The effectiveness of leadership models depends on the level of resistance to the change among powerful segments of the group, the lifespan of the social network involved, and the duration of influence of the leaders who are communicating the innovation.

Social Movement/Community Mobilization Theory

Describes how a culture's institutions, experiences, or characteristics can be changed by social movements begun by members of that culture. Local popular involvement and mobilization, such as occurred in gay and lesbian communities during the 1980s in response to AIDS, can be effective in creating change necessary for improving the health of a community. Existing or emerging local leaders usually initiate and maintain social movements, but they can also occur as a result of outside interventions.

Social Network Theory

Describes relationships or interactions between two or more people. Social networks are defined in terms of family relationships, friendships, or commercial relationships. Researchers characterize the focus of social networks either in terms of the individual and his or her relationships to others or in terms of any set of linkages among people in a given group or network. Understanding social networks is important in HIV prevention because transmission occurs between two people operating within a network.

Additionally, a person may serve as a link between two seemingly unconnected networks. Some research suggests that using a network as the target for an HIV prevention intervention may be effective, but additional research is needed to explore the use of social network theory in interventions.

Harm Reduction Model

Harm reduction is a philosophical approach to HIV/AIDS prevention that can be utilized with populations at high risk for HIV. Harm reduction models seek to reduce harm to the individual through the design of community-based programs that are client-centered, and where the population or individual you are trying to reach is involved at all stages of program/intervention design, development, and implementation.

The harm reduction model originated for drug using populations who do not seek traditional drug treatment options. In this population, use of traditional drug treatment is often unsuccessful or not readily available.

Harm reduction can be adapted to work with other populations. This approach provides other populations with important information and options to minimize and/or decrease their risk for HIV infection through drugs or sex.

Source: ***What Intervention Studies Say About Effectiveness: A Resource for HIV Prevention Community Planning Groups*****, 1996.** See http://www.healthstrategies.org/pubs/publications/InterventionEffectiveness.pdf